



Grantee/Organization Name: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

State of Residence: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Email: \_\_\_\_\_

How did the Komen New England funds help you (*please select all that apply*):

- Case management (referral to service, assistance in overcoming barriers to a service, etc.)
- Patient assistance (transportation, interpretation, child care to attend service, etc.)
- Screening mammogram
- Diagnostic service(s) (diagnostic mammogram, ultrasound, biopsy, etc.)
- Other (please specify):

If you received a diagnostic service(s), were you diagnosed with breast cancer?

- Yes       No

What did it mean to you to receive this assistance?

If you could say anything to Komen New England, what would it be?

Is there anything else you would like to share about the assistance you received?

***Please see next page***

Is it okay if Komen New England uses your story to promote the success of our grants programs?

Yes

No

May Komen New England contact you?

Yes

No

If yes, what is your preferred method of contact?

Phone

Email

Signature: \_\_\_\_\_ Date: \_\_\_\_\_